		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025619

Facility Name: Shawnee Christian Nursing Center

Address: 1901 North 13th P.O. Box 680 (Number) Herrin (City) 62948-0680 (Zip Code)

County: Williamson

Telephone Number: 618-942-7391 **Fax #** ( )

IDPA ID Number: 37-0841562005

Date of Initial License for Current Owners: 09/01/80

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501(C)3		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 1999 to June 30, 2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP
600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	159	Skilled (SNF)	159	58,194	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	159	TOTALS	159	58,194	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,441	2,551		8,992	8
9	SNF/PED					9
10	ICF	20,037	12,608		32,645	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,478	15,159		41,637	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.55%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/01/80

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/80 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	178,860	17,507	10,563	206,930		206,930	(8)	206,922			1
2	Food Purchase		173,469		173,469		173,469		173,469			2
3	Housekeeping	124,384	12,690		137,074		137,074		137,074			3
4	Laundry	68,769	10,621		79,390		79,390		79,390			4
5	Heat and Other Utilities			116,552	116,552		116,552	341	116,893			5
6	Maintenance	39,638	19,154	19,787	78,579		78,579	6,785	85,364			6
7	Other (specify):*											7
8	**TOTAL General Services**	411,651	233,441	146,902	791,994		791,994	7,118	799,112			8
	B. Health Care and Programs											
9	Medical Director			5,000	5,000		5,000		5,000			9
10	Nursing and Medical Records	1,458,480	47,961	60,006	1,566,447		1,566,447		1,566,447			10
10a	Therapy			22,479	22,479		22,479		22,479			10a
11	Activities	24,409			24,409		24,409		24,409			11
12	Social Services	84,710	1,488	3,707	89,905		89,905	(768)	89,137			12
13	Nurse Aide Training											13
14	Program Transportation		2,306		2,306		2,306		2,306			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,567,599	51,755	91,192	1,710,546		1,710,546	(768)	1,709,778			16
	C. General Administration											
17	Administrative	53,466	1,679	139,320	194,465		194,465	(103,833)	90,632			17
18	Directors Fees											18
19	Professional Services			2,127	2,127		2,127	19,282	21,409			19
20	Dues, Fees, Subscriptions & Promotions			26,606	26,606		26,606	(8,201)	18,405			20
21	Clerical & General Office Expenses	72,502	2,818	36,899	112,219		112,219	5,177	117,396			21
22	Employee Benefits & Payroll Taxes			292,095	292,095		292,095	6,665	298,760			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,240	5,240		5,240	2,595	7,835			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			13,601	13,601		13,601	1,424	15,025			26
27	Other (specify):*											27
28	**TOTAL General Administration**	125,968	4,497	515,888	646,353		646,353	(76,891)	569,462			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,105,218	289,693	753,982	3,148,893		3,148,893	(70,541)	3,078,352			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Shawnee Christian Nursing Center #0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			159,102	159,102		159,102	15,289	174,391			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			445,951	445,951		445,951	(5,751)	440,200			32
33	Real Estate Taxes			293	293		293	(293)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Finance fee & bond costs			6,642	6,642		6,642		6,642			36
37	**TOTAL Ownership**			611,988	611,988		611,988	9,245	621,233			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			380	380		380		380			39
40	Barber and Beauty Shops	19,142	806		19,948		19,948		19,948			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,292	87,292		87,292		87,292			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	19,142	806	87,672	107,620		107,620		107,620			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,124,360	290,499	1,453,642	3,868,501		3,868,501	(61,296)	3,807,205			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8)	1		4
5	Telephone, TV & Radio in Resident Rooms	(361)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,498	30		9
10	Interest and Other Investment Income	(5,751)	32		10
11	Discounts, Allowances, Rebates & Refunds	344	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(293)	33		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,754)	21		24
25	Fund Raising, Advertising and Promotional	(9,219)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(11,268)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (28,812)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(32,484)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (32,484)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (61,296)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Shawnee Christian Nursing Center

ID# 0025619

Report Period Beginning: July 1, 1999

Ending: June 30, 2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation revenue	$ (10,500)	21	1
2	Activity revenue	(768)	12	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(11,268)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(8)	0	0	0	0	0	0	0	0	0	0	(8)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(361)	702	0	0	0	0	0	0	0	0	0	341	5
6	Maintenance	0	6,785	0	0	0	0	0	0	0	0	0	6,785	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(369)	7,487	0	0	0	0	0	0	0	0	0	7,118	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(768)	0	0	0	0	0	0	0	0	0	0	(768)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(768)	0	0	0	0	0	0	0	0	0	0	(768)	16
	C. General Administration													
17	Administrative	0	(103,833)	0	0	0	0	0	0	0	0	0	(103,833)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,282	0	0	0	0	0	0	0	0	0	19,282	19
20	Fees, Subscriptions & Promotions	(9,219)	1,018	0	0	0	0	0	0	0	0	0	(8,201)	20
21	Clerical & General Office Expenses	(19,910)	25,087	0	0	0	0	0	0	0	0	0	5,177	21
22	Employee Benefits & Payroll Taxes	0	6,665	0	0	0	0	0	0	0	0	0	6,665	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,595	0	0	0	0	0	0	0	0	0	2,595	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,424	0	0	0	0	0	0	0	0	0	1,424	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(29,129)	(47,762)	0	0	0	0	0	0	0	0	0	(76,891)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,266)	(40,275)	0	0	0	0	0	0	0	0	0	(70,541)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	7,498	7,791	0	0	0	0	0	0	0	0	0	15,289	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,751)	0	0	0	0	0	0	0	0	0	0	(5,751)	32
33	Real Estate Taxes	(293)	0	0	0	0	0	0	0	0	0	0	(293)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,454	7,791	0	0	0	0	0	0	0	0	0	9,245	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,812)	(32,484)	0	0	0	0	0	0	0	0	0	(61,296)	45

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		5	Utilities	$	Christian Homes, Inc.	100.00%	$ 702	$ 702	1
2	V		6	Maintenance				6,785	6,785	2
3	V		17	Administrative	139,320			35,487	(103,833)	3
4	V		18	Directors						4
5	V		19	Professional Services				19,282	19,282	5
6	V		20	Fees/Subscriptions/Promotion				1,018	1,018	6
7	V		21	Clerical				25,087	25,087	7
8	V		22	Employee Benefits	4,800			11,465	6,665	8
9	V		23	In-Sevice						9
10	V		24	Travel and Seminar				2,595	2,595	10
11	V		26	Insurance				1,424	1,424	11
12	V		27	Human Resources						12
13	V		30	Depreciation				7,791	7,791	13
14	Total				$ 144,120			$ 111,636	$ * (32,484)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: ne 30, 2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This worksheet is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Virgil Hampton		x	Bldg. & Equipment	$1,950.00	09/01/80	$ 390,000	$ 129,911	09/01/00	0.0600	$ 23,400	1
2	CHI Revolving Loan Fund	x		Bldg. & Equipment	$1,291.00	07/01/80	164,317	137,313	11/01/07	0.0200	2,883	2
3	City of Herrin		x	Refinance Debt	$14,233.00	09/01/93	2,720,000	2,380,000	09/01/18	0.0700	168,350	3
4	GR Bonds (91C,96A,99A&00A)	x		Redeem/Refinance Debt	$20,957.00	Various	2,737,500	3,560,430	Various	Various	196,869	4
5	CHI BondFund	x		Refinance Debt	$4,500.00	12/31/97	1,600,166	120,583	05/01/48		54,449	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$42,931.00		$ 7,611,983	$ 6,328,237			$ 445,951	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,611,983	$ 6,328,237			$ 445,951	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	This w/p n/a	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,100 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	180,000	1980	$ 71,171	1
2	Home Office Allocation			6,682	2
3	TOTALS	180,000		$ 77,853	3

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155		1980	1971	$ 1,666,025	$ 44,338	35	$ 47,601	$ 3,263	$ 885,576	4
5			1980	1980	107,504		20	5,375	5,375	95,984	5
6											6
7											7
8	Home Office				47,684	1,558		1,558		20,702	8
	Improvement Type**										
9	Storage Building			1981	6,510	326	20	326		6,275	9
10	Roof Repair			1981	3,660		5			3,660	10
11	Hearing & A/C System			1982	37,091	1,855	20	1,855		33,699	11
12	TV System			1982	9,873	3	15		(3)	9,873	12
13	TV System			1982	1,182	59	20	59		1,052	13
14	Parking Lot			1982	42,223		15			42,223	14
15											15
16	Building Improvements			1982	159,808	4,098	39	4,098		75,813	16
17	Landscaping			1982	3,500		10			3,500	17
18	Parking Lot Improvement			1982	400		14			400	18
19	Building Improvements			1983	22,362	588	38	588		10,290	19
20	Roof Repair			1983	4,538		10			4,538	20
21	Smoke Alarm			1984	650	33	20	33		244	21
22	Building Improvements			1985	44,866	1,122	40	1,122		16,550	22
23	Roof Replacement			1985	192,604	5,503	35	5,503		82,545	23
24	Windows			1985	39,252	981	40	981		14,470	24
25	Ceiling Tile			1985	4,232	212	20	212		3,092	25
26	A/C System			1985	4,200		10			4,200	26
27	Light Fixtures			1985	777		10			777	27
28	Ceiling Tile			1986	1,874	94	20	94		1,277	28
29	Duct Work			1986	1,600	80	20	80		1,100	29
30	Building Improvements			1986	4,103	3	10		(3)	4,103	30
31	Wiring			1987	891	45	20	45		608	31
32	Dining & Adminstration Wing			1987	688,723	17,218	40	17,218		226,500	32
33	Landscaping			1987	3,083	3	10		(3)	3,083	33
34	Remodeling			1987	705	35	20	35		452	34
35	Ceiling Duct			1987	510	26	20	26		336	35
36	TOTAL (lines 4 thru 35)				$ 3,100,430	$ 78,180		$ 86,809	$ 8,629	$ 1,552,922	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Duct Work			1987	635	32	20	32		408	9
10	Energy System			1987	11,000	733	15	733		9,346	10
11											11
12	Remodeling			1988	552	28	20	28		345	12
13	Electrical Supply			1988	373	19	20	19		234	13
14	Air Cleaner & Duct			1988	1,694	4	10		(4)	1,694	14
15	Mirror			1988	1,562	2	10		(2)	1,562	15
16	HVAC System			1988	4,675	234	20	234		2,847	16
17	Windows			1988	705	20	35	20		242	17
18	Baseboard			1988	739	37	20	37		447	18
19	Sewer			1988	1,001	50	20	50		621	19
20	Heat Pumps			1988	27,223	1,361	20	1,361		16,445	20
21	Resurface Parking Lot			1988	3,285	164	20	164		1,968	21
22	Parking Lot Work			1988	372	19	20	19		226	22
23	Floor Tile			1988	340		5			340	23
24	Duct Work			1988	22,066	1,103	20	1,103		13,052	24
25	Roof Work			1988	1,254	84	15	84		1,008	25
26	Towel & Soap Dispenser			1988	1,976		10			1,976	26
27	Title Policy			1988	3,740	94	40	94		1,112	27
28	Hampton Settlement			1988	74,000	1,850	40	1,850		21,892	28
29	Wall Heat Pump			1989	1,300		10			1,300	29
30	Flourescent Light			1989	673	3	10		(3)	673	30
31	A/C Electrical Work			1989	6,950		8			6,950	31
32	Heat Pumps/Duct System			1989	39,940	1,997	20	1,997		21,967	32
33	D.D. Gate			1989	450		5			450	33
34	Sewer System Improvements			1989	10,000	500	20	500		5,500	34
35	Grinder Pump System			1989	11,624	101	10	102	1	11,624	35
36	TOTAL (lines 4 thru 35)				$ 228,129	$ 8,435		$ 8,427	$ (8)	$ 124,229	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Down Spouts			1989	600	40	15	40		433	9
10	Laundry Room Roof			1989	2,200	147	15	147		1,592	10
11	Courtyard Project			1989	8,326	416	20	416		4,506	11
12	Energy Management System			1989	5,692	379	15	379		4,074	12
13	Courtyard Sidewalks			1989	580	29	20	29		309	13
14	Heat Pumps			1989	63,466	3,173	20	3,173		33,321	14
15	Wander Guard			1989	11,417	571	20	571		5,995	15
16	Air Conditioning			1989	5,820		8			5,820	16
17	Ceiling Tile			1989	1,868	91	10	92	1	1,868	17
18	Landscaping			1989	517	26	20	26		273	18
19	Trimming (1200")			1990	840		5			840	19
20	Remodel Rooms			1990	2,446	122	20	122		1,280	20
21	Baseboard (120')			1990	706	1	5		(1)	706	21
22	Shelving			1990	851	1	5		(1)	851	22
23	Floor Tile			1990	426	1	5		(1)	426	23
24	Water Heater			1990	386	26	15	26		269	24
25	Smoke Detectors			1990	890		5			890	25
26	Flourescent Lights (20)			1990	775	47	10	47		775	26
27	Door & Hardware			1990	541	1	5		(1)	541	27
28	Wallpaper			1990	919		5			919	28
29	Relocate Sprinklers			1990	583	51	10	51		583	29
30	Brick A/C Holes			1990	1,352	34	40	34		346	30
31	Door Frames			1990	303		5			303	31
32	Paint & Wallpaper			1990	1,118		5			1,118	32
33	Heating Receivers (11)			1990	1,975	132	15	132		1,331	33
34	Fencing			1990	1,700	113	15	113		1,139	34
35	Kickplates			1990	763	76	10	76		760	35
36	TOTAL (lines 4 thru 35)				$ 117,060	$ 5,477		$ 5,474	$ (3)	$ 71,268	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscpae - Courtyard			1990	7,472	374	20	374		3,677	9
10	Air Conditioner			1990	1,184		8			1,184	10
11	Door Alarm			1990	423		5			423	11
12	Doors & Lock			1990	35,817	1,791	20	1,791		17,606	12
13	Drainage Work			1990	2,848	142	20	142		1,396	13
14	Patio Wall, Sidewalk			1990	8,000	400	20	400		3,931	14
15	Lights (13)			1990	590	59	10	59		580	15
16	Door Kickplates (118)			1990	2,104	210	10	210		2,029	16
17	Electrical Connection to Emergency Generator			1990	6,930	347	20	347		3,323	17
18	Remodeling			1991	2,733	137	20	137		1,300	18
19	Door Locks			1991	510	26	20	26		244	19
20	Floor Tile Install			1991	10,926		5			10,926	20
21	Cove Base			1991	1,763	176	10	176		1,642	21
22	Handrail, Drywall			1991	569		5			569	22
23	Exit Fixtures			1991	1,619	162	10	162		1,498	23
24	Sidewalk (840x4)			1991	2,100	105	20	105		963	24
25	Parking Curbs (30)			1991	385	39	10	39		354	25
26	A/C Units (2)			1991	15,885	1,589	10	1,589		14,432	26
27	Wallcoverings			1991	483		5			483	27
28	Culverts			1991	828	41	20	41		369	28
29	Landscaping			1991	709	35	20	35		311	29
30	Heat Pump			1991	5,267	351	15	351		3,096	30
31	Walk-in Freezer			1991	8,643	576	15	576		5,069	31
32	Drainage			1991	2,615	131	20	131		1,148	32
33	Brickwork			1991	6,200	310	20	310		2,677	33
34	Fencing			1991	1,380	92	15	92		788	34
35	Water Heater			1991	867	87	10	87		745	35
36	TOTAL (lines 4 thru 35)				$ 128,850	$ 7,180		$ 7,180	$	$ 80,763	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Gazebo Roofing			1992	8,216	411	20	411		3,440	9
10	Parking Lot Lights			1992	772	77	10	77		647	10
11	Hall Lights			1992	2,091	209	10	209		1,755	11
12	Water Heaters			1992	3,164	211	15	211		1,772	12
13	Heat Pump			1992	653	44	15	44		369	13
14	Landscaping			1992	2,794	140	20	140		1,133	14
15	Replace Drive			1992	900	45	20	45		363	15
16	Heat Pump			1992	7,265	484	15	484		3,901	16
17	4' Loop System			1992	3,723	372	10	372		2,980	17
18	Building Lighting			1992	1,142	114	10	114		902	18
19	Metal Door Frames			1992	840	42	20	42		330	19
20	Land Improvements			1992	1,000	50	20	50		390	20
21	Tub Room Remodel			1993	4,015	402	10	402		2,901	21
22	Building Remodeling			1993	6,103	305	20	305		1,628	22
23	Honeywell System			1993	5,031	252	20	252		1,764	23
24	Land Improvements			1993	750	38	20	38		266	24
25	Grease Trap			1993	1,750	175	10	175		1,204	25
26	Roof Repair			1993	4,608	307	15	307		2,025	26
27	Storage Room Remodel			1994	2,020	101	20	101		654	27
28	Sewage Pump System			1994	4,256	426	10	426		2,629	28
29	Fire/Garage Door			1994	526	1	5		(1)	526	29
30	Braille Door Sign			1994	2,598	260	10	260		1,576	30
31	Sink/Floor Tile			1994	1,694	79	10	79		924	31
32	Folding Door Divider			1994	551	28	5	28		551	32
33	Smokers Shelter			1994	4,921	492	10	492		2,788	33
34	Garbage Disposal			1994	610	51	5	51		610	34
35	See Attachment PG 12D (2)				285,093	18,911		18,911		63,257	35
36	TOTAL (lines 4 thru 35)				$ 357,086	$ 24,027		$ 24,026	$ (1)	$ 101,285	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Handrails			1995	6,079	608	10	608		3,138	9
10	Remodeling (Side 1)			1995	7,992	1,598	5	1,598		7,965	10
11	Cabinets			1995	2,343	156	15	156		787	11
12	Therapy/Bath			1996	181,372	7,557	24	7,557		32,184	12
13	Fire Alarm System Relay			1996	2,596	260	10	260		1,018	13
14	New addition sidewalk			1996	534	53	10	53		294	14
15	Cnvt Tub Room/Quiet			1997	1,296	259	5	259		863	15
16	Water Fountain			1997	502	100	5	100		325	16
17	Roof Repairs			1997	534	107	5	107		348	17
18	Compressor			1997	973	324	3	324		972	18
19	Compressor Unit 1516			1997	2,377	792	3	792		2,376	19
20	Roof Work			1997	1,276	255	5	255		701	20
21	Remodeling (Side 2 & 3)			1997	38,878	2,592	15	2,592		5,184	21
22	Replace/Rewire Hot Water Heater			1998	9,445	945	10	945		2,205	22
23	Kitchen Heaters			1998	793	159	3	159		344	23
24	Compressor/Library #24			1999	2,972	991	3	991		1,982	24
25	Keyless locks			1999	1,423	285	5	285		522	25
26	Wallpaper dining room			1999	3,071	614	5	614		768	26
27	120 gal water heater			1999	3,000	300	10	300		325	27
28	Mixing valve water heater			2000	961	176	5	176		176	28
29	Compressor			2000	1,133	284	3	284		284	29
30	Security control system			2000	940	63	10	63		63	30
31	Remodel admin office/wiring			2000	1,147	68	5	68		68	31
32	Rooftop cond unit			2000	3,373	56	10	56		56	32
33	4 ton A/C			2000	2,590	43	5	43		43	33
34	4 ton hest pumps			2000	4,780	40	10	40		40	34
35	See Attachment PG 12D (3)				2,713	226		226		226	35
36	TOTAL (lines 4 thru 35)				$ 285,093	$ 18,911		$ 18,911	$	$ 63,257	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PVC Fence			2000	2,713	226	10	226		226	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	See Attachment PG 12D (X)										35
36	TOTAL (lines 4 thru 35)				$ 2,713	$ 226		$ 226	$	$ 226	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 299,207	$ 33,679	$ 33,679	$		$ 187,758	37
38	Current Year Purchases	16,665	1,827	1,827			395	38
39	Fully Depreciated Assets	241,705					241,705	39
40	Home Office Allocations	41,621	4,296	4,296			33,842	40
41	TOTALS	$ 599,198	$ 39,802	$ 39,802	$		$ 463,700	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transport	1985 Van	1992	$ 14,250	$ 1,486	$ 367	$ (1,119)	5	$ 14,250	42
43	New motor		2000	3,323	369	369			369	43
44										44
45	Home Office Allocations			9,063	1,937	1,937			2,794	45
46	TOTALS			$ 26,636	$ 3,792	$ 2,673	$ (1,119)		$ 17,413	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,635,242	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 166,893	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 174,391	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 7,498	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,411,580	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Blinds/Drapes	$ 7,204	$	$ 7,204	52
53	Land	10,800			53
54					54
55					55
56					56
57	TOTALS	$ 18,004	$	$ 7,204	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 58,650	$	1
2	Cash-Patient Deposits	10,987		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 26,482)	246,573		3
4	Supply Inventory (priced at FIFO)	8,507		4
5	Short-Term Investments	133		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Int Rec	285		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 325,135	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	81,971		13
14	Buildings, at Historical Cost	3,746,596		14
15	Leasehold Improvements, at Historical Cost	137,276		15
16	Equipment, at Historical Cost	582,346		16
17	Accumulated Depreciation (book methods)	(2,258,374)		17
18	Deferred Charges	33,588		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	188,702		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,512,105	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,837,240	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 112,594	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,987		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	104,882		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	430		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Revolving Fund	137,813		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 366,706	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,061,013		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Annuity Payable	129,911		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,190,924	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,557,630	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,720,390)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,837,240	$	48

***(See instructions.)**

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,009,827)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,009,827)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(710,563)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (710,563)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,720,390)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,405,220	1
2	Discounts and Allowances for all Levels	(314,563)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,090,657	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	(2,402)	12
13	Barber and Beauty Care	16,526	13
14	Non-Patient Meals	8	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15,885	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 30,017	23
	D. Non-Operating Revenue		
24	Contributions	26,182	24
25	Interest and Other Investment Income***	11,974	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 38,156	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Unrealized G/(L) on Sale of Equip & Investments**	(892)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (892)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,157,938	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	791,994	31
32	Health Care	1,710,546	32
33	General Administration	646,353	33
	B. Capital Expense		
34	Ownership	611,988	34
	C. Ancillary Expense		
35	Special Cost Centers	20,328	35
36	Provider Participation Fee	87,292	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,868,501	40
41	**Income before Income Taxes (line 30 minus line 40)****	(710,563)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (710,563)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,315	2,641	$ 53,465	$ 20.24	1
2	Assistant Director of Nursing	1,771	2,020	37,905	18.76	2
3	Registered Nurses	12,065	13,764	236,260	17.17	3
4	Licensed Practical Nurses	24,172	27,575	321,303	11.65	4
5	Nurse Aides & Orderlies	88,540	101,006	782,225	7.74	5
6	Nurse Aide Trainees		0			6
7	Licensed Therapist		0			7
8	Rehab/Therapy Aides	3,163	3,608	27,322	7.57	8
9	Activity Director	1,630	1,860	24,409	13.12	9
10	Activity Assistants		0			10
11	Social Service Workers	9,162	10,452	84,710	8.10	11
12	Dietician		0			12
13	Food Service Supervisor		0			13
14	Head Cook		0			14
15	Cook Helpers/Assistants	20,689	23,602	178,860	7.58	15
16	Dishwashers		0			16
17	Maintenance Workers	3,831	4,370	39,638	9.07	17
18	Housekeepers	12,360	14,100	124,384	8.82	18
19	Laundry	8,343	9,518	68,769	7.23	19
20	Administrator	1,688	1,926	53,466	27.76	20
21	Assistant Administrator		0			21
22	Other Administrative		0			22
23	Office Manager	1,585	1,808	24,520	13.56	23
24	Clerical	5,370	6,126	47,982	7.83	24
25	Vocational Instruction		0			25
26	Academic Instruction		0			26
27	Medical Director		0			27
28	Qualified MR Prof. (QMRP)		0			28
29	Resident Services Coordinator		0			29
30	Habilitation Aides (DD Homes)		0			30
31	Medical Records		0			31
32	Other Health Care(specify)		0			32
33	Other(specify) Beauty shop	1,768	2,017	19,142	9.49	33
34	TOTAL (lines 1 - 33)	198,452	226,393	$ 2,124,360 *	$ 9.38	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	246	$ 10,563	1.3	35
36	Medical Director	20	5,000	9.3	36
37	Medical Records Consultant	1	44	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	13	480	10.3	39
40	Physical Therapy Consultant	281	16,830	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	1	43	10a.3	42
43	Speech Therapy Consultant	37	2,775	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	75	3,707	12.3	45
46	Other(specify) P.T. Asst.	12	337	10a.3	46
47	Dental	30	1,630	10.3	47
48	Utilization review	3	1,365	10.3	48
49	TOTAL (lines 35 - 48)	719	$ 42,774		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James E Burrell	Admiistrator	0	$ 53,466
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 53,466

B. Administrative - Other

Description	Amount
Management Fee	$ 139,320
TOTAL (agree to Schedule V, line 17, col. 3)	$ 139,320
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Craig, Bartelsmeyer	Legal	$ 225
Booth, Little & Antoline	Legal	34
Van Ostrand / E. Kelly	Legal	1,868
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 2,127

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,736
Unemployment Compensation Insurance	4,800
FICA Taxes	154,924
Employee Health Insurance	64,350
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Uniforms	0
Employee Expense	6,099
Employee Physicals	1,039
Workers Comp. Med. Expense	4,147
Related Party Adjustment	(4,800)
Home Office Allocation	11,465
TOTAL (agree to Schedule V, line 22, col.8)	$ 298,760

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,262
Health Care Worker Background Check	
(Indicate # of checks performed)	
Promotional & Marketing	9,219
Dues & Subscriptions	1,107
Licences and fees	313
Life Services Network	4,649
Home office allocation	1,018
Computer services	1,056
Less: Public Relations Expense	(4,042)
Non-allowable advertising	(5,177)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,405

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,293
Seminar Expense	947
Home Office Allocation	2,595
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,835

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 1999 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $4,649**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,624** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **87,292**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **No** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **10,500**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **To be provided upon completion**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.